FORMS

Number	Name	Revision Date
DHHS 126	Confidential Complaint	06/2007
DHHS 130	Claim Adjustment Form 130	03/2007
DHHS 205	Medicaid Refunds	01/2008
DHHS 931	Health Insurance Information Referral Form	01/2008
	Reasonable Effort Documentation	05/2007
	Authorization Agreement for Electronic Funds Transfer	03/2011
	Duplicate Remittance Advice Request Form	10/2012
CMS-1500	Sample Claim Showing Medicaid and Medicare with NPI	08/2005
CMS-1500	Sample Claim Showing Medicaid Only with NPI	08/2005
CMS-1500	Sample Claim Showing Medicaid and Private Pay with NPI and Medicaid Provider ID	08/2005
CMS-1500	Sample Claim Showing Medicare, Medicaid, Private Pay with NPI and Medicaid Provider ID	08/2005
	Sample Edit Correction Form	10/2008
	Sample Remittance Advice	06/2007
DME 001	Medicaid Certificate of Medical Necessity Equipment/Supplies	04/2010
DME 003	Medicaid Certificate of Medical Necessity Power/Manual Wheelchairs and/or Accessories	04/2010
DME 004	Medicaid Certificate of Medical Necessity Orthotics, Prosthetics, and Diabetic Shoes	04/2010
DME 005	Medicaid Certificate of Medical Necessity Enteral Nutrition	04/2010
DME 006	Medicaid Certificate of Medical Necessity Parenteral Nutrition	04/2010
DME 007	Medicaid Certificate of Medical Necessity Oxygen	04/2010
DME 008	Certificate of Repair and Labor Cost	02/2010
	Justification for Home Uterine Activity Monitor/Supplies (HUAM) for Subcutaneous Tocolytic Therapy	02/2013

FORMS

Number	Name	Revision Date
HASCI-12-F	SC Dept of Disabilities and Special Needs Head and Spinal Cord Injury Waiver Authorization for PERS Services	02/2004
HASCI 12-I	SC Dept of Disabilities and Special Needs Head and Spinal Cord Injury Waiver Authorization for Specialized Supplies and Adaptations	02/2004
DHHS 214	Prior Authorization	04/1997



STATE OF SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

CONFIDENTIAL COMPLAINT

SEND TO: DIRECTOR, DIVISION OF PROGRAM INTEGRITY
DEPARTMENT OF HEALTH AND HUMAN SERVICES

P.O. BOX 100210, 1801 MAIN STREET, COLUMBIA, SOUTH CAROLINA 29202-3210

PROGRAM INTEGRITY

THIS REPORT IS DESIGNED FOR THE REPORTING OF POSSIBLE ABUSE BY MEDICAID PROVIDERS AND/OR RECIPIENTS. USE THE SPACE BELOW TO EXPLAIN IN DETAIL YOUR COMPLAINT. PLEASE IDENTIFY YOURSELF AND WHERE YOU CAN BE REACHED FOR FUTURE REFERENCES. UNLESS OTHERWISE INDICATED, ALL INFORMATION SHOULD BE PRINTED OR TYPED.

YOUR COMPLAINT WILL REMAIN CONFIDENTIAL.

SUSPECTED INDIVIDUAL OR INDIVIDUALS:							
NPI or MEDICAID PROVIDER ID: (if applicable)		MEDICAID RECIPIENT ID NUM	BER: (if applicable)				
ADDRESS OF SUSPECT:		LOCATION OF INCIDENT:					
		DATE OF INCIDENT:					
COMPLAINT:							
NAME OF PERSON REPORTING: (Please print) SIGNAT REPORT		TURE OF PERSON DATE OF REPORT RTING:					
ADDRESS OF PERSON REPORTING:		TELEPHONE NUMBER OF PERSON REPORTING:					
		SIGNATURE: (SCDHHS Representative Receiving Report)					

South Carolina Department of Health and Human Services - Claim Adjustment Form 130

Provider Name: (Please use black or blue ink when completing form) Provider Address: Total paid amount on the original claim: Provider City, State, Zip: Original CCN: NPI: Provider ID: Recipient ID: Originator: Adjustment Type: ○Void/Replace ODHHS. O MCCS Provider Void Reason For Adjustment: (Fill One Only) Insurance payment different than original claim Medicaid paid twice - void only Keying errors Incorrect provider paid Incorrect dates of service paid Incorrect recipient billed Voluntary provider refund due to health insurance Provider filing error Voluntary provider refund due to casualty Medicare adjusted the claim Voluntary provider refund due to Medicare Other For Agency Use Only Analyst ID: Hospital/Office Visit included in Surgical Package Independent lab should be paid for service Web Tool error Assistant surgeon paid as primary surgeon Reference File error Multiple surgery claims submitted for the same DOS MCCS processing error MMIS claims processing error Claim review by Appeals Rate change Comments:

Signature:__ Date: Phone:

South Carolina Department of Health and Human Services Form for Medicaid Refunds

Purpose: This form is to be used for all refund checks made to Medicaid. This form gives the information needed to properly account for the refund. If the form is incomplete, the provider will be contacted for the additional information.

Items 1, 2 or 3, 4, 5, 6, & 7 must b	e completed.	Attach ap	Attach appropriate document(s) as listed in item 8.					
1. Provider Name:								
2. Medicaid Legacy Provider #	(Six Cl	naracters)						
OR 3. NPI#		& Taxon	omy					
4. Person to Contact:		_ 5. Telepl	hone Number:					
6. Reason for Refund: [check ap	propriate box]							
Other Insurance Paid (please complete a – f below and attach insurance EOMB) a Type of Insurance: () Accident/Auto Liability () Health/Hospitalization b Insurance Company Name c Policy #: d Policyholder: e Group Name/Group: f Amount Insurance Paid: Medicare () Full payment made by Medicare () Deductible not due () Adjustment made by Medicare Requested by DHHS (please attach a copy of the request) Other, describe in detail reason for refund:								
7. Patient/Service Identification:								
Patient Name	Medicaid I.D.# (10 digits)	Date(s) of Service	Amount of Medicaid Payment	Amount of Refund				
8. Attachment(s): [Check approp	riate box]		1					
Explanation of Bene	f Health and Human	ledicare (if appli	icable)	S				

DHHS Form 205 (01/08)



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID HEALTH INSURANCE INFORMATION REFERRAL FORM

	Provider or Department Name:	Provider ID or NPI:					
	Contact Person:	Phone #: Date:					
I	ADD INSURANCE FOR A MEDICAID MANAGEMENT INFORMATION SYS	BENEFICIARY WITH NO INSURANCE IN THE MEDICAID TEM (MMIS) – ALLOW 25 DAYS					
	Beneficiary Name:	Date Referral Completed:					
	Medicaid ID#:	Policy Number:					
	Insurance Company Name:	Group Number:					
	Insured's Name:	Insured SSN:					
	Employer's Name/Address:						
II	CHANGES TO AN INSURANCE RECO	ORD THAT IS IN THE MMIS – MIVS SHALL WORK WITHIN 5 DAYS					
	a. beneficiary has never	been covered by the policy – close insurance.					
	b. beneficiary coverage	ended - terminate coverage (date)					
	c. subscriber coverage l	apsed - terminate coverage (date)					
	d. subscriber changed p	lans under employer - new carrier is					
	- new policy number is						
	e. beneficiary to add to i	nsurance already in MMIS for subscriber or other family member.					
	(name)						
	ATTACH A COPY OF T	THE APPROPRIATE DOCUMENTATION TO THIS FORM.					
	Submit this informa Fax:	ation to Medicaid Insurance Verification Services (MIVS). or Mail:					
	803-252-08						
Ш		ANCE IN THE MMIS WITH THE SUBSCRIBER SSN y numbers and plans to replace existing insurance records through MMIS es are available.)					
	Medicaid Beneficiary ID:	SSN:					
	Carrier Name/Code:	New Unique Policy Number:					
	Submit this information to So Fax:	uth Carolina Department of Health and Human Services (SCDHHS). or Mail:					
	803-255-8225	Post Office Box 8206, Attention TPL Columbia, SC 29202-8206					



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES REASONABLE EFFORT DOCUMENTATION

PROVIDER	DOS
NPI or MEDICAID PROVIDER ID	
MEDICAID BENEFICIARY NAME	
MEDICAID BENEFICIARY ID#	
INSURANCE COMPANY NAME	
POLICYHOLDER	
POLICY NUMBER	
ORIGINAL DATE FILED TO INSURANCE COMPANY	
DATE OF FOLLOW UP ACTIVITY	
RESULT:	
FURTHER ACTION TAKEN:	
DATE OF SECOND FOLLOW UP	
RESULT:	
I HAVE EXHAUSTED ALL OPTIONS FOR OBTAINING A PAY FROM THE PRIMARY INSURER.	MENT OR SUFFICIENT RESPONSE
(SIGNATURE AND DATE)	

ATTACH A COPY OF FORM TO THE APPROPRIATE CLAIM OR ECF AND FORWARD TO YOUR MEDICAID CLAIMS PROCESSING POST OFFICE BOX.

South Carolina Department of Health and Human Services Electronic Funds Transfer (EFT) Authorization Agreement

PROVIDER INFORMATION		
Provider Name		V
Medicaid Provider Number		
Provider NPI Number	contraction of the contraction o	
Provider Address		1 2011 - Anna Diego (1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 - 1880 -
City	State	Zip
BANKING INFORMATION (Please include letterhead. This is required and the information		
Financial Institution Name		-
Financial Institution Address		:
City	State	Zip
Routing Number (nine digit)		
Account Number		
Type of Account (check one)	Savings	
I (we) hereby authorize the Department of Hoto initiate, if necessary, debit entries for any the financial institution named below, to cree entries will pertain only to the Department resulting from Medicaid services rendered by I (we) understand that credit entries to the understanding that payment will be from the statements or documents or concealments of federal or state laws. I (we) certify that the information shown is considered to the address shown below prior to respect to the statements of the statement of	credit entries in error to dit and/or debit the salt of Health and Humon of the provider. account of the above federal and/or state of a material fact, ma	to my account indicated below and time to such account. These credit ian Services payment obligations in named payee are done with the funds and that any false claims, by be prosecuted under applicable to provide thirty (30) days written
Contact Name:	Phone	Number:
Signed		(Signature)
		(Print)
Title	Date	j

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.

RETURN COMPLETED FORM & BANK VERIFICATION DOCUMENT TO:

Department of Health and Human Services Medicaid Provider Enrollment P.O. BOX 8809, COLUMBIA, S.C. 29202-8809 FAX (803) 870-9022

South Carolina Department of Health and Human Services Duplicate Remittance Advice Request Form

Purpose: This form is to be used for all requests for duplicate remittance advices from South Carolina Medicaid. The form must be completed in its entirety in order to honor the request. If the form is incomplete, the form will be returned requesting the additional information.

Please contact the SCDHHS Provider Service Center (PSC) at 1-888-289-0709 or submit an online inquiry at http://www.scdhhs.gov/contact-us for instructions on submission of your request.

1.	Provider Name:					
2. Medicaid Legacy Provider # (Six Characters)						
	NPI# & Taxonomy					
3.	Person to Contact: 4. Telephone Number:					
5.	Requesting:					
	□ Complete Remittance □ Remittance Pages □ Edit Correction Pages Only					
6.	Please list the date(s) of the remittance advice for which you are requesting a duplicate copy:					
7.	Street Address for delivery of request:					
	Street: City:					
	State:					
	Zip Code:					
8.	Charges for a duplicate remittance advice are as follows:					
	Request Processing Fee - \$20.00					
	Page(s) copied <u>20 per page</u>					
	lerstand and acknowledge that a charge is associated with this request and will be deducted my provider's payment by debit adjustment on a future remittance advice.					
Auth	orizing Signature Date					

SCDHHS (Revised 10/2012)

[1500]

HEALTH INSURANCE CLAIM FORM

Durable Medical Equipment Sample Claim Showing Medicaid and Medicare With NPI

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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	MEDICARE MEDICAID TRICARE CHAMPVA CHAMPUS CHAMPUS	— HEALTH PLAN — BLK LUNG —	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	1				
	(Medicare #) X (Medicaid #) (Sponsor's SSN) (Member IDe	(SSN or ID) (SSN) (ID)	1234567890					
	2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John A.	8. PATIENT'S BIRTH DATE SEX 01 01 1947 M _X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
	-	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	$\exists I$				
	123 Windy Lane	Self Spouse Child Other						
	-	8. PATIENT STATUS	CITY STATE					
	Anytown SC	Single Married Other		ATIC				
	ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)	RMA				
	29999 ()	Employed Student Student	()	-NFOR				
	e. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 123456789999					
	a, OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)						
	a. OTHER INSURED S POLICY ON GROUP NUMBER	YES X NO	a, INSURED'S DATE OF BIRTH SEX	INSI				
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	c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	ENT				
		YES X NO	620					
	d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	PA				
		1	YES NO If yes, return to and complete item 9 a-d.					
	READ BACK OF FORM BEFORE COMPLETING 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the re to process this claim. I also request payment of government benefits either to below.	elease of any medical or other information necessary	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. 					
	Signature on File	DATE	SIGNED					
	OIGHED		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	= 1				
	MM DD YY INJURY (Accident) OR G	PATIENT HAS HAD SAME OR SIMILAR ILLNESS.	FROM DD YY MM DD YY	- 11				
	17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 178.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DO YY	$\exists I$				
	17b.	NP(FROM TO					
	19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES					
	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3	or 4 to Item 24F by Line)	22. MEDICAID RESUBMISSION	$-\parallel$				
	. 846 D	*	ORIGINAL REF. NO.					
	1. 040, 0	'	23. PRIOR AUTHORIZATION NUMBER	$\exists I$				
	2. 4.							
	24. A. DATE(S) OF SERVICE B. C. D. PROCED	URES, SERVICES, OR SUPPLIES E. DIAGNOSIS	F. G. H. I. J. DAYS EFSUT D. RENDERING	7				
	From To		F. G. H. I. J. DAYS EPSOT ID. RENDERING Family QUAL. PROVIDER ID. #	_				
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	555555555 X DOE1234	27. ACCEPT ASSIGNMENT? [For govt. claims, see back) X YES NO	\$ 90\00 \$ 0\00 \$ 90\00	را ر اا ر				
		ILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (555) 5555555	$\exists $				
	INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse		ABC Medical Supply					
	apply to this bill and are made a part thereof.)		111 Main Street					
			Anytown, SC 22222-2222					
	SIGNED DATE 8. NP	b.	a. 1234567890 D. ZZ1212121212	Y				

[1500]

HEALTH INSURANCE CLAIM FORM

Durable Medical Equipment Sample Claim Showing Medicaid Only With NPI

Modicard	APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05						
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SIGNED S	12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the to process this claim. I also request payment of government benefits either	release of any medical or other information necessary to myself or to the party who accepts assignment		undersigned physician or supplier for			
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Durable Medical Equipment Sample Claim Showing Medicaid and Private Pay

CARRIER HEALTH INSURANCE CLAIM FORM With NPI and Medicaid Provider ID APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05 1. MEDICARE . MEDICARE MEDICAID TRICARE CHAMPUS (Medicare #) X (Medicaid #) (Sponsor's SSN) MEDICAID CHAMPVA GROUP
HEALTH PLAN
(Member ID#) X (SSN or ID) 1a, INSURED'S I.D. NUMBER (For Program in Item 1) FECA BLKLUNG (SSN) 1234567890 (ID) 2, PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATJENT'S BIRTH DATE 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 01 01 1947 M_X Doe, John A. 5. PATIENT'S ADDRESS (No., Street) 7. INSURED'S ADDRESS (No., Street) 6. PATIENT RELATIONSHIP TO INSURED 123 Windy Lane Spouse Other STATE 8. PATIENT STATUS AND INSURED INFORMATION SC Anytown ZIP CODE TELEPHONE (Include Area Code) ZIP CODE ELEPHONE (Include Area Code) 29999 Employed Student 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: 11. INSURED'S POLICY GROUP OR FECA NUMBER 01200000A a, INSURED'S DATE OF BIRTH a. OTHER INSURED'S POLICY OR GROUP NUMBER a. EMPLOYMENT? (Current or Previous) YES М b. OTHER INSURED'S DATE OF BIRTH b. AUTO ACCIDENT? b. EMPLOYER'S NAME OR SCHOOL NAME PLACE (State) X NO 22.00 М F c. OTHER ACCIDENT? c. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME 401 x NO d. INSURANCE PLAN NAME OR PROGRAM NAME 10d. RESERVED FOR LOCAL USE d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES X NO If yes, return to and complete item 9 a-d. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Signature on File SIGNED ILLNESS (First symptor INJURY (Accident) OR PREGNANCY(LMP) IS. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY 14. DATE OF CURRENT G PROVIDER OR OTHER SOURCE HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 17, NAME OF REFERRI 17a. FROM DD TO 19. RESERVED FOR LOCAL 22. MEDICAID RESUBMISSIO 21. DIAGNOSIS OR NATURE OF ILLNESS RIGINAL REF. NO. 846 0 a l 23. PRIOR AUTHORIZATION NUMBER DATE(S) OF SERVICE PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
CPT/HCPCS | MODIFIE RENDERING D. \$ CHARGES мм DD DD POINTER SERVICE MODIFIER PROVIDER ID. 1D ABC123 01 20 07 01 20 07 12 A4253 00 90 00 2 NPI 1234567890 8 NPI SUPPL NPI 4 OR NPI 5 6 NPI 25, FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 28. TOTAL CHARGE 29. AMOUNT PAID 30, BALANCE DUE ACCEPT ASSIGNMENT? (For govt. claims, see back) 555555555 22 00 \$ 68 00 DOE1234 90 00 \$ X YES Х 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS 32, SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # (555) 5555555 ABC Medical Supply (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 111 Main Street Anytown, SC 22222-2222

a 1234567890



HEALTH INSURANCE CLAIM FORM

Durable Medical Equipment Sample Claim Showing Medicare, Medicaid, and Private Pay With NPI and Medicaid Provider ID

ADDROVED BY MATCHES UNIFORM OF THE COMMITTEE COLOR		With NET and Medicald Provider ID
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		PICA
	MPVA GROUP FECA OTHER	R 1a, INSURED'S I.D. NUMBER (For Program in Item 1
CHAMPUS —	MPVA GROUP FECA OTHER BLKLUNG BLKLUNG BLKLUNG (SSN) (ID)	1234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John A.	a PATIENT'S BIRTH DATE SEX	* HOOTED O HAME (East Halls, Flist Halls, Middle Hillar)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7, INSURED'S ADDRESS (No., Street)
123 Windy Lane	Self Spouse Child Other	T. Modries or services (rec., orece)
	ATE 8, PATIENT STATUS	CITY STATE
l de la companya de		CITY STATE
Anytown S ZIP CODE TELEPHONE (Include Area Code)	C Single Married Other	ZIP CODE TELEPHONE (Include Area Code)
	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)
29999 ()	Employed Student Student	()
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
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012345678	YES X NO	M_ F_
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
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c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
50.00	YES X NO	400
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
620	1	X YES NO If yes, return to and complete item 9 a-d
READ BACK OF FORM BEFORE COMPL	TING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authoriz to process this claim. I also request payment of government benefits. 		payment of medical benefits to the undersigned physician or supplier services described below.
below.	nation to imposit of to the party with accepts accepts acception.	SCIVICOS GOOCIEDOS ESCIVIDAS.
Signature on File	DATE	SIGNED
ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	FROM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
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555555555 X DOE1:	234 X YES NO	\$ 90 00 \$ 50 00 \$ 40
	E FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (555) 5555555
INCLUDING DEGREES OR CREDENTIALS		ABC Medical Supply
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)		111 Main Street
		Anytown, SC 22222-2222
	NIDI b	
SIGNED DATE a.	MEI	a. 1234567890 h. 1DABC123

CLAIM CONTROL #9999999999999999 RUN DATE 05/01/2007 000001204 SC DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORT NUMBER CLM3500 EDIT CORRECTION FORM PAGE 1136 ECF 1136 PAGE 1 OF 1 ANALYST ID HIC - 76 SPEC -EMC Y SIGNON ID DOC IND N ORIGINAL CCN: SFL ZIP: TAXONOMY: PRV ZIP: ADJ CCN: 3 4 5 6 7 8 9 1 2 EDITS PROV/XWALK RECIPIENT P AUTH TPL INJURY EMERG PC COORD ---- DIAGNOSIS ----INSURANCE EDITS CODE NUMBER PRIMARY SECONDARY ID ABC123 1111111111 871.3 CLAIM EDITS NPI: 1234567890 LINE EDITS 01) 714 10 RECIPIENT NAME - DOE, JANE 11 DATE OF BIRTH 01/25/1992 12 SEX F ******** ** AGENCY USE ONLY 13 14 15 16 17 18 19 20 21 22 INDIVIDUAL CHARGE PAY UNITS ** ALLOWED LN DATE OF PLACE PROC MOD APPROVED EDITS NO SERVICE CODE PROVIDER IND 23 ** REJECTED LINE EDITS NDC ********* .00 02/01/00 12 V2624 DME000 65.00 1 OLT 001 NPI: 1234567890 TAXONOMY: / / 2 ! CLAIMS/LINE PAYMENT INFO ! NPI: TAXONOMY: / / ! EDIT PAYMENT DATE ! NPI: TAXONOMY: / / NPI: TAXONOMY: / / NPI: TAXONOMY: / / NPT: TAXONOMY: / / NPI: TAXONOMY: / / NPI: TAXONOMY: 24 25 26 INS CARR POLICY INS CARR NUMBER NUMBER 27 TOTAL CHARGE 1765.00 PAID 01 28 AMT REC'D INS 02 29 BALANCE DUE 1765.00 03 OWN REF # 012345 RESOLUTION DECISION ADDITIONAL DIAG CODES:

> RETURN TO: INSURANCE POLICY INFORMATION

MEDICAID CLAIMS RECEIPT P. O. BOX 1412

COLUMBIA, S.C. 29202-1412

PROVIDER:

ACME DME SUPPLIERS

PO BOX 00000

ANYWHERE XO 00000-0000

^{*} INDICATES A SPLIT CLAIM

Sample Remittance Advice (page 1)
This page of the sample Remittance Advice shows a paid claim, as well as a Void/Replacement claim for which both the Void and the Replacement processed during the same payment cycle.

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Sample Remittance Advice (page 2)
This page of the sample Remittance Advice shows a claim-level Void without a corresponding Replacement claim.

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Sample Remittance Advice (page 3)

This page of the sample Remittance Advice shows four gross-level adjustments. Gross-level adjustments always appear on the final page of the Remittance Advice.

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PROVIDERS OWN REF. NUMBER	REFERENCE NUMBER	SERVICE DATE(S) MMDDYY	PROC / DRUG CODE	RECIPIENT	•	NAME F M	ORIG.	ORIGINAL PAYMENT	 ACTION	DEBIT /	
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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Reci	pient's name:	Medicaid # (10	digits):
(2) DOP	S:/: Sex: HT: (in)	WT: Date of Service:	
(3) Prov	ider's name:	Provider's DME #	NPI#
(4) Stree	et address:	_ City: State:	Zip:Local telephone #:
(5) Prov	ider's signature:	Date:	
(6) LIST	ALL PROCEDURE CODES THAT ARE ORDERE	D BY THE TREATING/ORDERING PHYSI	ICIAN FOR EQUIPMENT/SUPPLIES:
MAI	TE: FOR ALL PROCEDURE CODES THAT A NUFACTURER PRICE LIST. ON B: ALL FIELDS IF APPLICABLE M	· 	AN ESTABLISHED PRICE, YOU MUST INCLUDE TING/ORDERING PHYSICIAN:
(7) Diag	mosis codes (ICD-9) Description(s):		
Aml	cate patient's ambulatory status while performi oulatory with the aid of a walker or cane,A e patient have decubitus ulcers? Yes No	mbulatory, with other assistance as desc	•
Please d	lescribe how this equipment / supply is medicall	y necessary, the benefits to the recipient	and how long will it take for the benefit to be
(9) For	supplies, please indicate the dressing change re-	quired per day, week, month, etc.	
Is addit	ional information attached on separate sheet? _ lent		ipient's name & I.D. Medicaid number on
(10) Ple	ase indicate the date that the patient was seen for	or the equipment/supplies prescribed:	
(11) Ple	ase indicate the prescription date:	<u></u>	
(Pl	ration of need (maximum of 12 months): _ ease indicate duration by months, not to ex	ceed 12).	
that the		mplete, to the best of my knowledge, and I un	need hereto has been reviewed and signed by me. I certify inderstand that any falsification, omission or concealment oment/supplies are appropriate for the patient.
(13) PHY	YSICIAN'S NAME :	P	HYSICIAN'S NPI #:
PHY	YSICIAN'S SIGNATURE	DATE//(SIGNATUR	RE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR EQUIPMENT/SUPPLIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND

MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in

pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date-

PROVIDER'S NAME, DME #

AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS

AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must include

manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering

this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).

QUESTION SECTION: These fields are used to gather clinical information to help Medicaid determine the medical necessity

for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR

EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician

assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment

and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 60 days of the date of

treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed

invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require

use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the

equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B;

(2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND

DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and

date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's

signature also certifies the item(s) order is medically necessary for this patient.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name:Medicaid # (10 digits)				
(2) DOB/; Sex: HT:	(in); WT:	Date of Service:		
(3) Provider's name:		Provider's DME #	NPI#:	
(4) Street address:	City:	State: Zip:	Local telephone #:	
(5) Provider's signature:		Date:		
(6) LIST ALL PROCEDURE CODES THAT ARE OR	RDERED BY THE TREATIN	IG/ORDERING PHYSICIAN ON:		
PLEASE NOTE: FOR ALL PROCEDURE CODES T MANUFACTURER PRICE LIST. I ATTEST THAT THE PT/OT THERAPIST AND/OR COMPANY.				
	LICADI E MUST D	E COMBLETED DV T	DE A TINIC /ODDEDING	
SECTION B: ALL FIELDS IF APPI PHYSICIAN:	LICABLE MUST B	E COMPLETED BY T	KEATING/UKDEKING	
(7) Diagnosis codes (ICD-9): Diagnosis	s(s):			
(8) Indicate the patient's mobility limitation & ex	aplain how it interferes wit	th the performance of activities	of daily living (ADLs):	
• Explain why a cane or walker is not sufficient	t to meet the patient's mob	oility needs in the home:		
• Explain why a manual wheelchair is not suffice	cient to meet the patient's	mobility needs in the home:		
How long has the condition been present and	what is the patient's clinic	cal progression:		
Indicate any related diagnosis and all other in	nterventions tried and the	results:		
Has the patient ever used a walker, manual or	r power wheelchair and w	hat were the results?		
(9) Please indicate the date that the patient was (10) Prescription Date:		-		
(22) Zaradon vi nece (vitalinum vi 12 montils).				
I certify that I am the treating/ordering physician ident that the medical necessity information is true, accurate material fact may subject me to civil or criminal liabilit	and complete, to the best of r	ny knowledge, and I understand the	at any falsification, omission, or concealment of	
(12) PRINT PHYSICIAN'S NAME:		NPI #		
PHYSICIAN'S SIGNATURE:	DATE	/ / (SIGNATURE AND	D DATE STAMPS ARE NOT ACCEPTABLE)	

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR POWER/MANUAL WHEELCHAIRS AND/OR ACCESSORIES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND

MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in

pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date-

PROVIDER'S NAME, DME#

AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS

AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must

include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering

this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).

QUESTION SECTION: This information is used to gather clinical information to help Medicaid determine the medical

necessity for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR

EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician

assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment

and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 60 days of the date of

treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed

invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require

use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the

equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B;

(2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND

DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and

date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's

signature also certifies the item(s) order is medically necessary for this patient.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name:	Medicaid # (10 d	Medicaid # (10 digits):				
(2) DOB:/; Sex: HT:	(in); WT:	Date of Service:				
(3) Provider's name:	Provider's DME # _	N	PI#			
(4) Street address:	City:	State:Zip:	Local telephone #:			
(5) Provider's signature:		Date:				
(6) LIST ALL PROCEDURE CODES THAT ARE O DIABETIC SHOES.			ORTHOTICS, PROSTHETICS, AND/OR			
PLEASE NOTE: FOR ALL PROCEDURE CODES TO MANUFACTURER PRICE LIST.	THAT ARE COVERED BUT DO	NOT HAVE AN ESTABLISH	ED PRICE, YOU MUST INCLUDE			
SECTION B: ALL FIELDS IF APPLICAB	LE MUST BE COMPLET	ED BY TREATING/ORI	DERING PHYSICIAN:			
(7) Diagnosis codes (ICD-9): Diagnos	sis (s):					
(8) Give a detailed description of the severity of	the recipient's condition(s) as	related to orthotics, prosthe	etics, and/or diabetic shoes.			
Orthotics and/or Prosthetics:						
<u>Diabetic Shoes:</u> Does the patient have one or mo	ore of the following conditions	? Check all that apply:				
History of previous foot ulcerations			•			
Poor circulation Is additional information attached on a separate	History of partial or complete	-	History of pre-ulcerative callus			
attachment)	sneet:1esNo (II	yes, enter recipient s nan	ic and Medicaid L.D. number on			
(9) Please indicate the date that the patient was	s seen for the equipment/suppl	ies prescribed:				
(10) Prescription Date:						
(11) Duration of need (Maximum of 12 months): (Please indicate duration by months, not to						
I certify that I am the treating/ordering physician identhat the medical necessity information is true, accurate material fact may subject me to civil or criminal liability.	e and complete, to the best of my l	knowledge, and I understand th	at any falsification, omission, or concealment of			
(12) PHYSICIAN'S NAME:		NPI #				
PHYSICIAN'S SIGNATURE:	DATE/_	/(SIGNATURE AN	D DATE STAMPS ARE NOT ACCEPTABLE)			

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 004 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR ORTHOTICS, PROSTHETICS AND DIABETIC SHOES

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND

MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in

pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date-

PROVIDER'S NAME, DME #

AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS

AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must

include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering

this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity

for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR

EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician

assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment

and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 60 days of the date of

treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed

invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require

use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the

equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B;

(2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND

DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and

date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's

signature also certifies the item(s) order is medically necessary for this patient.

DME 004 - Dated 01/01/11

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR ENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name:		Medicaid	# (10 digits):	
(2) DOB:/; Sex: HT:	(in); WT:	_ Date of Service:		
(3) Provider's name:	Provider's DME #		NPI#	
(4) Street address:	City:	State:	Zip:	Local telephone #:
(5) Provider's signature:		Date:		
(6) LIST ALL PROCEDURE CODES ORDERED BY T	HE TREATING/ORDERING	PHYSICIAN FOR EN	TERAL NUTRI	TTION.
PLEASE NOTE: FOR ALL PROCEDURE CODES MANUFACTURER PRICE LIST.	THAT ARE COVERED, B	UT DO NOT HAVE	AN ESTABLIS	SHED PRICE, YOU MUST INCLUDE
SECTION B: IF FIELDS IF APPLICABLE M	MUST BE COMPLETE	D BY TREATING/	ORDERING	S PHYSICIAN:
(7) Diagnosis codes (ICD-9): Diagnosis	(s):			
(8) Does the patient have permanent non-function bowel? Yes No				h or be absorbed from the small
Does the patient require tube feedings to provide health status? Yes No				
Product name (s):				
Total calories Per Day:				
The method of administration: Syringe G	ravity Pump	_Does not apply	_•	
Does the patient have a documented allergy or in	ntolerance to semi-synthetic	c nutrients? Yes	No	
Is additional information attached on separate she	eet?YesNo (If "yes,	" enter recipient's na	me & Medica	id I.D. number on attachment)
(9) Please indicate the date that the patient was see	en for the equipment/suppl	ies prescribed:		
(10) Enter the prescription date:				
(11) Duration of need (Maximum of 12 months): (Please indicate duration by months, not to ex				
I certify that I am the treating/ordering physician identithat the medical necessity information is true, accurate a material fact may subject me to civil or criminal liability	and complete, to the best of my	knowledge, and I under	rstand that any	falsification, omission, or concealment of
(12) PHYSICIAN'S NAME:			NPI#	·
PHYSICIAN'S SIGNATURE	DATE/	/(SIGNATURE	E AND DATE S	TAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

DME 005 – Dated 01/01/11

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND

MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in

pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date-

PROVIDER'S NAME, DME#

AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS

AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must

include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering

this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity

for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR

EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician

assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment

and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 60 days of the date of

treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed

invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require

use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the

equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B;

(2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND

DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and

date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's

signature also certifies the item(s) order is medically necessary for this patient.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1) Recipient's name:			Medicaio	l # (10 digits)	:
(2) DOB://	; Sex: HT: (i	n); WT:D	ate of Service:		
(3) Provider's name:		Provider's DME #	····	NPI#	
(4) Street address:		City:	State:	Zip:	Local telephone #:
(5) Provider's signature:			Date:		
(6) LIST ALL PROCEDURE (CODES THAT ARE ORDERE	D BY THE TREATING/OR	DERING PHYSICI	AN FOR PARI	ENTERAL NUTRITION:
	L PROCEDURE CODES TH ACTURER PRICE LIST.	IAT ARE COVERED, BUT	DO NOT HAVE	AN ESTABL	ISHED PRICE, YOU MUST INCLUDE
SECTION B: ALL FIEL	DS IF APPLICABLE MU	UST BE COMPLETEI	BY TREATIN	G/ORDERI	ING PHYSICIAN:
(7) Diagnosis codes (ICD-9)	: Diagnosis (s):				
(8) Does the patient have ser	vere permanent disease of th nmensurate with the patient	he gastrointestinal tract ca's overall health status?	ausing malabsorp Yes No	tion severe en	ough to prevent maintenance of
				<u>·</u>	
Formula components:	Amino Acid.	(ml/day)	concentratio	on%	gms protein/day
	Dextrose.	(ml/day)	concentratio	on%	
	Lipids.	(ml/day)	days/weeks		concentration%.
Check the method of ad	ministration: Central line _	Hemodialysis acce	ss line	Peripherally	inserted catheter (PIC)
Is additional information a	ttached on separate sheet? _	YesNo (If "yes", er	nter recipient's na	me & Medica	aid I.D. number on attachment)
(9) Please indicate the date	that the patient was seen fo	or the equipment/supplies	prescribed:		
(10) Enter the prescription	date:				
(11) Duration of need (Maxi (Please indicate duratio	imum of 12 months):n by months, not to exceed 1	12).			
that the medical necessity info		complete, to the best of my kr	owledge, and I und	erstand that ar	been reviewed and signed by me. I certify ny falsification, omission, or concealment of appropriate for the patient.
(12) PHYSICIAN'S NAME: _			NPI #		
PHYSICIAN'S SIGNAT					

PLEASE REFER TO THE MEDICAID CMN POLICY IN SECTION 2 OF THE DME MEDICAID PROVIDER MANUAL.

DME 006 – Dated 01/01/11

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR PARENTERAL NUTRITION

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND

MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in

pounds.

DATE OF SERVICES: Indicate the date of service (DOS). The date of service must be the same as the delivery date-

PROVIDER 'S NAME, DME #

AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS

AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must

include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering

this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity

for the item(s) being ordered. Answer each question which applies to the items ordered.

DATE PATIENT WAS SEEN FOR

EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician

assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment

and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 60 days of the date of

treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed

invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require

use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the

equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B;

(2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND

DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and

date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's

signature also certifies the item(s) order is medically necessary for this patient.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES MEDICAID CERTIFICATE OF MEDICAL NECESSITY FORM FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER:

(1)	Recipient's name:	Medicaid # (10 digits):
(2)	DOB//	; Sex: HT:(in); WT Date of service://
(3)	Provider's name:	Provider's DME #NPI #
(4)	Street address:	City:State:Zip:Local telephone #
(5)	Provider's signatu	re:Date:
(6)	LIST ALL PROC	EDURE CODES THAT ARE ORDERED BY THE TREATING/ORDERING PHYSICIAN FOR EQUIPMENT:
SEC	CTION B: MUST	BE COMPLETED BY TREATING/ORDERING PHYSICIAN:
(7) I	Diagnosis codes (ICI	D-9) (Descriptions):
(8) A	ANSWERS	ANSWER QUESTIONS 1-9. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted)
b)	mm Hg %	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO2 and/or (b) oxygen saturation test, Enter date of test (c)
	/ N	2. Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?
1 2	2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXX	XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7) Print/type name and address below NAME: ADDRESS:
	N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D
	LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "X"
		6-60 OR OXYGEN SATURATION = < 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.
	N 7	7. Does the patient have dependent edema due to congestive heart failure?
	N D	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y	N D	9. Does the patient have a hematocrit greater than 56%?
		VERING SECTION C QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print:TITLE:EMPLOYER:
(9)]	Please indicate the o	late that the patient was seen for the equipment/supplies prescribed:
(10)	Please indicate the	Prescription date:
		naximum of 12 months):
I cer	tify that I am the treathe medical necessity	ating/ordering physician identified in Section B of this form. Any statement attached hereto has been reviewed and signed by me. I certify information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission or concealment of me to civil or criminal liability. Additionally, I certify that the requested equipment/supplies are appropriate for the patient.
(12)	PHYSICIAN'S NAM	ENPI#
	PHYSICIAN'S SIGN	ATUREDATE//(SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

PLEASE REFER TO THE MEDICAID CMN POLICY IN THE DME MEDICAID PROVIDER MANUAL.

INSTRUCTIONS FOR COMPLETING THE MEDICAID CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN

SECTION A: MUST BE COMPLETED BY DME PROVIDER

RECIPIENT'S NAME AND

MEDICAID #: Indicate the patient's name and his/her Medicaid # (10 digits).

PATIENT DOB, SEX, HEIGHT, WEIGHT: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in

pounds.

DATE OF SERVICE: Indicate the date of service (DOS). The date of service must be the same as the delivery date-

PROVIDER'S NAME, DME #

AND NPI#: Indicate the name of the DME company (Provider name), Provider's DME# and NPI#.

PROVIDER'S PHYSICAL ADDRESS

AND TELEPHONE NUMBER: Indicate the provider's physical address (provider's location) and telephone number.

PROVIDER SIGNATURE AND DATE: Signature of DME provider representative and date.

HCPCS CODES: List all HCPCS procedure codes for items ordered by the treating/ordering physician.

Note: For all procedure codes that are covered, but do not have an established price, you must

include manufacturer price list.

SECTION B: MUST BE COMPLETED BY TREATING/ORDERING PHYSICIAN:

DIAGNOSIS CODES: In the first field, list the ICD-9 diagnosis code(s) that represent(s) the primary reason(s) for ordering

this item. In the second field, list the description(s) for each ICD-9 diagnosis code(s).

QUESTION SECTION: This section is used to gather clinical information to help Medicaid determine the medical necessity

for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y

for yes, "N" for no, or "D" for does not apply.

NAME OF PERSON ANSWERING

SECTION B QUESTIONS: If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, diction) or a physician ampleyed analysis appropriate the question of Section P. helde must print his therapist.

dietician) or a physician employee answers the question of Section B, he/she must print his/her name, give his/her professional title and name of his/her employer where indicated. If the physician is

answering the question, this space may be left blank.

DATE PATIENT WAS SEEN FOR

EQUIPMENT/SUPPLIES PRESCRIBED: Indicate the date patient was seen by the treating/ordering physician, nurse practitioner or physician

assistant for the equipment/supplies prescribed. The treating/ordering physician, nurse practitioner or physician assistant must examine the beneficiary within 60 days before prescribing equipment

and/or supplies.

PRESCRIPTION DATE: Indicate the prescription date. The prescription date must be within 60 days of the date of

treating/ordering physician's signature and the date the beneficiary was seen by the physician, nurse practitioner, or physician assistant. All MCMNs that are not signed within this time frame will be returned (if submitted with a PA) or rejected (if attached to a claim) and the MCMN will be deemed

invalid.

EST. LENGTH OF NEED: Indicate the estimated length of need (the length of time the physician expects the patient to require

use of the order item) by filling in the appropriate number of months, up to 12 months. An MCMN can be valid up to a maximum of 12 months from the date the patient was seen for the

equipment/supplies prescribed.

PHYSICIAN ATTESTATION: The physician signature certifies (1) the CMN which he/she is reviewing includes Sections A and B;

(2) answers in Section B are correct and the self-identifying information in Section A is correct.

PHYSICIAN SIGNATURE AND

DATE: After completion and/or review by the physician of Sections A and B the physician's must sign and

date the CMN in Section B, verifying the Attestation appearing in this Section. The physician's

signature also certifies the item(s) order is medically necessary for this patient.



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF DURABLE MEDICAL EQUIPMENT CERTIFICATE OF REPAIR AND LABOR COST



TO BE COMPLETED BY ENROLLED DME PROVIDER									
(1) RECIPIENT'S NAME:									
(2) RECIPIENT'S MEDICAID # (10 DIGITS):									
(3) BRAND NAME OF EQUIPMENT:		(4) DAT	E OF REF	PAIR AND	OR LABO	OR:			
(5) SPECIFICALLY IDENTIFY EQUIPMENT TO BE	REPAIRED:								
(6) ESTIMATED COST OF REPAIR:									
(7) GIVE A DETAILED DESCRIPTION OF THE TYPE	PE OF REPAIR A	ND/OR LAE	SOR TO BI	E PERFO	RMED ON	I EQUIPM	1ENT:		
(8) PROVIDER'S NAME:		PRO	VIDER ID	and/or NF	기:				
(9) STREET ADDRESS:		CITY	CITY:						

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF REPAIR AND LABOR COST

LINE 1	RECIPIENT'S NAME	Enter recipient's full name.
LINE 2	RECIPIENT'S MEDICAID#	Enter recipient's 10-digit Medicaid number.
LINE 3	BRAND OF EQUIPMENT	Enter the brand name of the equipment you are repairing.
LINE 4	DATE OF REPAIR AND/OR LABOR	Enter the date the repair and/or labor was performed.
LINE 5	SPECIFICALLY IDENTIFY EQUIPMENT TO BE REPAIRED	Specify equipment being repaired.
LINE 6	ESTIMATED COST OF REPAIRED	Enter estimated cost of repair. This cost must be itemized if you are repairing more than one item. Please use the additional space at the bottom of this form if needed.
LINE 7	GIVE A DETAILED DESCRIPTION OF THE TYPE OF REPAIR AND/OR LABOR TO BE PERFORMED ON EQUIPMENT	Give a detailed description of what type of repair was performed.
LINE 8	PROVIDER'S NAME & PROVIDER ID AND/OR NPI	Enter provider's name and Medicaid DME number and/or National Provider Identifier.
LINE 9	STREET ADDRESS AND CITY	Enter provider's street address and city.



JUSTIFICATION FOR HOME UTERINE ACTIVITY MONITOR/SUPPLIES (HUAM) FOR SUBCUTANEOUS TOCOLYTIC THERAPY

PART I - (PART I – (ALL INFORMATION MUST BE PRINTED)					
Patient's Nar	ne	Medicaid #:				
Date Telepho	one Order/Written Order Given:	•				
Patient's Exp	ected Date of Delivery:					
Provider's NF	Provider's NPI or Medicaid ID:					
<u>PART II</u>	The patient must have a gestational age of at least 24 week weeks AND meet AT LEAST ONE of the following criteria w home uterine activity monitor/supplies and/or subcutaneous (AT LEAST ONE OF THE FOLLOWING CRITERIA Management of the following criteria with the following criteria w	hich necessitates a us tocolytic therapy: IUST BE CHECKED) or that on for IV uses, zation				
	Patient has uterine anomalies or placenta previa that has required or will require hospitalization for IV tocolytic therapy.					
<u>PART III</u>						
	Additionally, the patient must also meet <u>ALL</u> of the following criteria:					
1)	 The patient has been diagnosed with pre-term labor based on uterine activity and/or cervical changes. 					
2)	2) The patient has been stabilized by tocolytic medication.					
3)	There are no contraindications to the continuation of this pregnancy.					
4)	There is no fetal distress.					
5)	The patient's membranes are intact.					
6)	6) The patient is on homebound status and is agreeable to bed rest activities.					

PART IV	Physician Certification	
I,(Patient's Name), qualifies for Ho and that the patient meets the ab		rtify that ineous Tocolytic Therapy based on medical necessity
Ordering/Treating Physician's Sig	gnature:	Date:
Physician UPIN/License #:		Phone #:

The patient has a telephone and is agreeable to daily phone contact and frequent physician follow-up.

The patient is assigned to a delivering physician who has back up coverage in his/her absence.

If the patient is hospitalized, this service will allow her to be discharged.

The patient would have to be hospitalized for uterine activity monitoring and/or subcutaneous tocolytic therapy, if this service

This form MUST be signed within 60 days of ordering service.

7)

8)

9)

10)

were not offered.

South Carolina Department of Disabilities and Special Needs Head and Spinal Cord Injury Waiver Authorization for PERS Services

Medica		6 7 8 9 10
Referred To:	, , , , , , , , , , , , , , , , , , , ,	0 / 8 9 10
neierieu 10.		
Individuals Name	Address	
Date of Birth	City/State/Zip	
Prior Authorization Number:		
Filor Authorization Number:	1 2 3 4 5 6 7	
Billing should be submitted to:	☐ DHHS ☐ DSN Board	
You are hereby authorized to provide:	_	
PERS Services		
PERS Installation (S516Ø)	Start Date:	
PERS Monitoring (S5161)	Start Date:	_
Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provide	er for PERS Services.	_
PLEASE PRINT		
DSN Board Name:	Svc. Coord.:	
Address:		
Phone: () - ext.		
Signature:	Date:	

South Carolina Department of Disabilities and Special Needs Head and Spinal Cord Injury Waiver Authorization for Specialized Supplies and Adaptations

Medic	caid #:	4 5 0 7 0 0 10	
Referred To:	1 2 3	4 5 6 7 8 9 10	
Individuals Name	Address		
Date of Birth	City/State/Zip		
Prior Authorization Number:	Billing should be sub	mitted to: DHHS DSN Board	
1 2 3 4 5 6 7			
You are hereby authorized to provide:			
Specialized Supplies & Adaptations (X1922)	Start Date		
Item:	Cost:	Frequency:	
	Cost:	Frequency:	
Item:	Cost:	Frequency:	
Item:	Cost:	Frequency:	
	dual diapers needed	Ctart Data	
Child - small/medium size (A4529) Child - large size (A4			
☐Youth (A4533)			
Adult - small size (A4521) Adult - medium size (A4522)	Adult - large size (A4	523) Adult - extra large size (A4524)	
☐HASCI Waiver Underpads (A4554)	Start Date:		
Amount: 1 case 2 cases 3 cases			
☐ Environmental Modification (S5165) (Home Modi		Start Date:	
Description:	22	Cost:	
Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provid PLEASE PRINT	er for Waiver Services.		
DON Board Name	Svc. Coord.:		
Address:			
Phone: _(
Signature:	i	Date:	
Ciuriature.	,	MIE	

PRIOR AUTHORIZ	ATION	1 CLAIM CONTROL NUMBER	R (DO NOT WRITE IN THIS SPACE)
		TYPEWRITER ALIGNMENT	(DO NOT WAITE IN THIS SPACE)
		USE CAPITAL LETTERS ONLY	
PROVIDER INFORMATION PROVIDERS NAME 2 STREET ADRESS		PROVIDER ID NUMBER OWN REFI	ERANCE # DATE SUBMITTED
6 CITY/ STATE/ZIP 7		NAME AND CITY OF MEDICAL PROVIDER	PRIOR AUTHORIZATION #
RECIPIENT INFORMATION RECIPIENT NAME (FIRST, MIDDLE INITIAL, LA	ST)	RECIPIENT ID NUMBER	SEX BIRTH DATE
SERVICE NDICATOR SERVICE CODE 14 15 SERVICE NAME 24	MODIFIER TYPE OF SALE	REQUESTED REPSDT REFERRAL PROPOSED CHARGE 18 19 20 TOOTH # TOOTH SURFACES 25 26	AUTHORIZED *BILLINGS DELETE 21 22 23 AUTHORIZED CHARGE EXPIRATION DATE 27 28
SERVICE NDICATOR SERVICE CODE 29 30 30 SERVICE NAME 39	MODIFIER TYPE OF SALE 31 32	REQUESTED REFERRAL PROPOSED CHARGE 33 34 35 TOOTH # TOOTH SURFACES	AUTHORIZED *BILLINGS DELETE 36 37 38 38 AUTHORIZED CHARGE EXPIRATION DATE
SERVICE INDICATOR SERVICE CODE 44	MODIFIER TYPE OF SALE	REQUESTED REPSOT REFERRAL PROPOSED CHARGE 48 49 50 1 1 TOOTH # TOOTH SURFACES	AUTHORIZED *BILLINGS DELETE 51 52 53 AUTHORIZED CHARGE EXPIRATION DATE
SERVICE INDICATOR SERVICE CODE 59 60 SERVICE NAME 69	MODIFIER TYPE OF SALE	REQUESTED REFERRAL PROPOSED CHARGE 63 64 65 1 TOOTH # TOOTH SURFACES	AUTHORIZED BILLINGS DELETE 66 67 68 68 AUTHORIZED CHARGE EXPIRATION DATE
SERVICE INDICATOR SERVICE CODE 74 75 SERVICE NAME 84	MODIFIER TYPE OF SALE	REQUESTED EPSDT REFERRAL PROPOSED CHARGE 78 79 80 1 TOOTH # TOOTH SURFACES 85 86	AUTHORIZED * BILINGS DELETE 81 82 83 83 AUTHORIZED CHARGE EXPIRATION DATE
		DOCUMENTATION TOTAL LINES TOTAL PROPOSED CHARGES 89 90 91	TOTAL AUTHORIZED CHARGES 92
900 000	EXPL	AIN MEDICAL NECESSITY FOR EA	CH PROCEDURE BELOW
BUCCAL Cross (X) Missing Teein X		x	

93 REVIEWED BY (FOR DEPARTMENT USE ONLY)

94 PROVIDERS SIGNATURE

DHHS FORM 214 (4/97) Replaces DSS Form 3204 (1-79) which may be used until exhausted.